SERFF Tracking Number:	*ELAS-125895993*	*State:*	*Arkansas*
Filing Company:	*AXA Equitable Life and Annuity Company*	*State Tracking Number:*	*40849*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Informational AMIGV-2009 et al (AXAEQLA)*		
Project Name/Number:	*Individual Life/AMIGV-2009*		

Filing at a Glance

Company: AXA Equitable Life and Annuity Company

Product Name: Informational AMIGV-2009 et al (AXAEQLA)	SERFF Tr Num: ELAS-125895993	State: ArkansasLH
TOI: L08 Life - Other	SERFF Status: Closed	State Tr Num: 40849
Sub-TOI: L08.000 Life - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Authors: Audrey Arnold, Maria Castaldo, Samra Mekbeb, Roxanne Persaud, Sabrena Lallmohamed, Joan Robertson	Disposition Date: 11/14/2008
	Date Submitted: 11/13/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Individual Life	Status of Filing in Domicile: Not Filed
Project Number: AMIGV-2009	Date Approved in Domicile:
Requested Filing Mode: Informational	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 11/14/2008	
State Status Changed: 11/14/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

VIA SERFF

November 13, 2008

The Honorable Julie Benafield Bowman, Insurance Commissioner

SERFF Tracking Number:	*ELAS-125895993*	*State:*	*Arkansas*
Filing Company:	*AXA Equitable Life and Annuity Company*	*State Tracking Number:*	*40849*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Informational AMIGV-2009 et al (AXAEQLA)*		
Project Name/Number:	*Individual Life/AMIGV-2009*		

1200 West Third Street
Little Rock, AR 72201-1904

Re: AXA Equitable Life and Annuity Company (AXAEQLA)
AXAEQLA's FEIN: 13-3198083
AXAEQLA's NAIC #: 968-62880
Corrective Filing for Informational Purposes:
Forms AMIGV-2009- Approved Individual Life Insurance Application
180-6010 (2009)- Approved Optional Benefits Supplement
SERFF Tracking Number: ELAS-125895993

Dear Commissioner:

We are filing for informational purposes, as described below, previously approved forms AMIGV-2009 and 180 6010 (2009) (SERFF Tracking Number: SERFF Tracking Number: ELAS-125849355; State Tracking Number: 40556-). We certify that these forms have not yet been made available for use.

We have revised question 37b on page 3 of the enclosed AMIGV-2009 application to state: "What is the nature of the relationship between the Proposed Insured and the Trustee?" This question on such application that was previously submitted to the Department incorrectly stated "Trust Protector."

In our initial submission, we inadvertently omitted the brackets around the marketing names and optional benefit riders for the Company's non-variable life products that are shown on form 180-6010 (2009). The enclosed form 180-6010 (2009) now includes brackets around the information that corresponds to the Statement of Variability shown below (and which was also shown in our initial cover letter).

Statement of Variability:

1. We have bracketed the Home Office and Mailing Address as they may change in the future.

2. The product marketing names and product specific optional benefit riders are bracketed to allow for any future

changes. We certify that we will not offer any new product specific optional benefit riders without gaining prior approval by the Department.

We are sorry for this inconvenience, and we assure the Department that all other information of the approved application submission is correct and that there are no other changes to the submission.

We are forwarding to you today, via EFT (Electronic Fund Transfer), $40.00 for the filing fee.

I certify that, to the best of my knowledge and belief, we comply with all the requirements of Arkansas Rule and Regulation 33 regarding variable life insurance.

I certify that, to the best of my knowledge and belief, we comply with all the requirements of Arkansas Rule and Regulation 34 regarding universal life insurance. We will comply with the requirements of Bulletin 11-83. Any change in current cost of insurance rates will be filed with the Department on an informational basis.

I certify that the information required by Ark. Code 23-79-138 is provided with every life insurance policy issued in Arkansas.

The Life and Health Guarantee Association Notice required by Rule and Regulation 49 is provided with each policy delivered in Arkansas. I certify that we comply with this regulation.

Please call me at (212) 314-2921 or Maria Castaldo at (212) 314-2226 if you have any further questions or need additional information regarding this filing.

Sincerely,

Estella A. Devian, Vice President

Company and Contact

Filing Contact Information

Estella A. Devian, Vice President estella.devian@axa-financial.com

SERFF Tracking Number:	*ELAS-125895993*	*State:*	*Arkansas*
Filing Company:	*AXA Equitable Life and Annuity Company*	*State Tracking Number:*	*40849*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Informational AMIGV-2009 et al (AXAEQLA)*		
Project Name/Number:	*Individual Life/AMIGV-2009*		

1290 Avenue of the Americas, 14th Floor
New York, NY 10104
(212) 314-2921 [Phone]
(212) 707-7493[FAX]

Filing Company Information

AXA Equitable Life and Annuity Company	CoCode: 62880	State of Domicile: Colorado
Administrative Office	Group Code: 968	Company Type: Life Insurance
1290 Avenue of the Americas, 14-10		
New York, NY 10104	Group Name:	State ID Number:
(212) 314-2921 ext. [Phone]	FEIN Number: 13-3198083	

SERFF Tracking Number:	*ELAS-125895993*	*State:*	*Arkansas*
Filing Company:	*AXA Equitable Life and Annuity Company*	*State Tracking Number:*	*40849*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Informational AMIGV-2009 et al (AXAEQLA)*		
Project Name/Number:	*Individual Life/AMIGV-2009*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$40.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AXA Equitable Life and Annuity Company	$40.00	11/13/2008	23897556

SERFF Tracking Number:	*ELAS-125895993*	*State:*	*Arkansas*
Filing Company:	*AXA Equitable Life and Annuity Company*	*State Tracking Number:*	*40849*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Informational AMIGV-2009 et al (AXAEQLA)*		
Project Name/Number:	*Individual Life/AMIGV-2009*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	11/14/2008	11/14/2008

SERFF Tracking Number:	*ELAS-125895993*	*State:*	*Arkansas*
Filing Company:	*AXA Equitable Life and Annuity Company*	*State Tracking Number:*	*40849*
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Product Name:	*Informational AMIGV-2009 et al (AXAEQLA)*		
Project Name/Number:	*Individual Life/AMIGV-2009*		

Disposition

Disposition Date: 11/14/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ELAS-125895993*	*State:*	*Arkansas*
Filing Company:	*AXA Equitable Life and Annuity Company*	*State Tracking Number:*	*40849*
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Project Name/Number:	*Individual Life/AMIGV-2009*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Form	Individual Life Application		Yes
Form	Optional Benefits Application Supplement		Yes

SERFF Tracking Number:	*ELAS-125895993*	*State:*	*Arkansas*
Filing Company:	*AXA Equitable Life and Annuity Company*	*State Tracking Number:*	*40849*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Informational AMIGV-2009 et al (AXAEQLA)*		
Project Name/Number:	*Individual Life/AMIGV-2009*		

Form Schedule

Lead Form Number: AMIGV-2009

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AMIGV-2009	Application/ Enrollment Form	Individual Life Application	Revised	Replaced Form #: AMIGV-2005 Previous Filing #:	57	AMIGV-2009, Life Insurance Application (info filings).pdf
	180-6010 (2009)	Application/ Enrollment Form	Optional Benefits Application Supplement	Revised	Replaced Form #: 180-6010 Previous Filing #:	58	180-6010 (2009), Optional Benefits Supplement.pdf

AXA EQUITABLE

1290 Avenue of the Americas, New York, NY 10104

(Select One)
- ☐ AXA Equitable Life Insurance Company
- ☐ AXA Equitable Life and Annuity Company
- ☐ MONY Life Insurance Company of America
- ☐ MONY Life Insurance Company

Application for Life Insurance
(Part 1)

PRODUCT AND AMOUNT OF INSURANCE

Riders and Optional Benefits: Complete Optional Benefits Supplement for all non-variable products, and VUL Supplement for variable products.

1. Product Name: _____ **2. Amount of Insurance:** $_____

3. Is this a Term Conversion or Purchase Option? ☐ Yes ☐ No (If Yes, complete Term Policy/Rider Conversion or Purchase Option Supplement.)

PROPOSED INSURED 1

Q2: If **Proposed Insured(s) is age 65 or older** and sum of face amounts applied for with AXA Equitable and all affiliated companies within past 12 months equals **$2 million** or more, Financial Supplement II is required.

For **Proposed Insured(s) under age 65** and sum of face amounts applied for with AXA Equitable and all affiliated companies within past 12 months equals **$2 million** or more, Financial Supplement is required.

Q7: If address is a P.O. Box or not an actual residence, proof of residence is required.

***Q7:** County required in AL, FL, GA, KY, LA and SC.

Q9: Max 6 months prior to application date.

Q11: If "Yes," provide license number; if "No," provide government ID number, if any.

Q14: If "No," complete Foreign Residence and Travel Supplement.

Q15: If less than 1 year at current occupation, give previous employment in Remarks Section.

4. Name:

_____
First Middle Last

5. SS#: _____

6. Gender: ☐ Male ☐ Female

7. Residence Address:

_____
No. & Street Bldg./Apt./Suite

_____
City/Municipality County* State Zip Code

8. Date of birth: _____ (mm/dd/yyyy)

8a. Birthplace:

_____
Country State

9. Backdate to save age: ☐ Yes ☐ No

10. Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

11. Do you have a driver's license? ☐ Yes ☐ No

Number: _____

State: _____ Expiration date: _____

12. Phone numbers: Home _____

Work _____ Cell _____

Best time to call: _____ ☐ a.m. ☐ p.m.
☐ Home ☐ Work ☐ Cell

13. E-mail address:

_____

14. U.S. citizen: ☐ Yes ☐ No

15. Currently employed: ☐ Yes ☐ No ☐ Retired
Years at current job: _____

16. Current occupation:

_____
Title Employer name

_____
Occupation/Duties

_____
Employer address (No. & Street)

_____
(City, State, Zip Code)

PROPOSED INSURED 2 (IF APPLICABLE)

4. Name:

_____
First Middle Last

5. SS#: _____

6. Gender: ☐ Male ☐ Female

7. Residence Address:

_____
No. & Street Bldg./Apt./Suite

_____
City/Municipality County* State Zip Code

8. Date of birth: _____ (mm/dd/yyyy)

8a. Birthplace:

_____
Country State

9. Backdate to save age: ☐ Yes ☐ No

10. Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

11. Do you have a driver's license? ☐ Yes ☐ No

Number: _____

State: _____ Expiration date: _____

12. Phone numbers: Home _____

Work _____ Cell _____

Best time to call: _____ ☐ a.m. ☐ p.m.
☐ Home ☐ Work ☐ Cell

13. E-mail address:

_____

14. U.S. citizen: ☐ Yes ☐ No

15. Currently employed: ☐ Yes ☐ No ☐ Retired
Years at current job: _____

16. Current occupation:

_____
Title Employer name

_____
Occupation/Duties

_____
Employer address (No. & Street)

_____
(City, State, Zip Code)

APPLICANT, IF PROPOSED INSURED IS UNDER AGE 15

Applicant is the party who initiates and applies for the life insurance. In most cases, applicant and owner are the same, but in some instances, like parent as policy owner, grandparent as applicant, they are different.

17. Complete if Proposed Insured is under age 15:

a) Total amount of insurance in force on the life of: Applicant: $ _____

Total amount of insurance in force on the life of: Parent(s)/Legal Guardian if other than Applicant: $ _____

b) Any other children in family insured for a lesser amount? ☐ Yes ☐ No If Yes, details: _____

c) Is Applicant different from Owner? ☐ Yes ☐ No Applicant's name: _____

Applicant's SS#: _____ Relationship to Proposed Insured: _____

Applicant's Address: _____
No. & Street | Bldg./Apt./Suite | City/Municipality | State | Zip Code

PREMIUM AND COVERAGE-RELATED INFORMATION

Complete questions 18 and 19 for UL and VUL only.

18. Death Benefit Option:
☐ Option A (Level) ☐ Option B (Increasing)

19. Definition of Life Insurance Test:
☐ Guideline Premium Test ☐ Cash Value Accumulation Test

20. Premium amount: $ _____
(For VUL and UL, enter planned periodic premium.)

21. Initial premium: $ _____
(For VUL and UL, state initial premium if different than planned periodic premium.)

Q22: To authorize use of a CWA checking account for Systematic drafts, please write the following statement in the REMARKS section: "Use CWA Check in lieu of Voided Check".

22. Method of Payment: **a.** Bank draft* (Voided Check is Required) ☐ Monthly ☐ Quarterly (UL and VUL products only.)

Start date: _____ (dd/mm/yyyy) Draft date on _____ of each deduction (VUL and UL only.)

*If bank account holder is not the Owner or Proposed Insured, please complete Systematic Payment Enrollment Form.

b. Direct ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

c. Single payment $ _____ (No further billing will be sent.)

d. Salary Allotment:* ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

*If Allotter is not Proposed Insured, provide Name: _____ SSN#/EIN/ITIN: _____

Unit name: _____ Unit number: _____ Register date: _____

OWNERSHIP INFORMATION Complete if Proposed Insured is not the Owner (If additional space is required, use Remarks Section)

For Joint Owners provide name, residential address, Social Security #, date of birth, driver's license #, state of issue and expiration date, occupation and employer's name in Remarks Section.

Q26: Billing notices will be sent to the Owner at this address unless otherwise directed in Remarks Section. If P.O. Box, put residential address in Remarks Section.

Q28: If "Yes," provide license number; if "No," provide government ID number, if any.

Complete for Individual, Trust, Corporation, Partnership, Entity, et al:

23. Owner's name: _____

23a. Person(s) authorized to transact business on behalf of Owner.

Name: _____ Title: _____

24. ☐ SSN ☐ EIN or ☐ ITIN: _____ **25.** Relationship to Proposed Insured: _____

26. Address: _____
No. & Street | City | State | Zip Code

Complete Question 27 for all non-resident (foreign) Owners. If the Owner is not a U.S. Person (U.S. Citizen or U.S. Corporation, Partnership or Trust established or organized under the laws of a state of the United States), then he, she or it may have to provide additional documentation, including IRS form W-8 BEN. Any foreign Owner (Individual, Trust, Corporation, Partnership, Entity, et al;) must have a US bank account.

27. U.S. bank name: _____ Account number: _____

Individual

28. Do you have a driver's license? ☐ Yes ☐ No

Number: _____ State: _____ Expiration date: _____

29. Date of birth: _____ (mm/dd/yyyy) **30.** Currently employed? ☐ Yes ☐ No ☐ Retired

31. Employer name: _____ **32.** Occupation: _____

33. U.S. citizen?: ☐ Yes ☐ No (If "No" please complete "a" and "b" or "c," where applicable.)

a) Country of citizenship: _____ Date of entry into the U.S.: _____ (mm/dd/yyyy)

b) Residents with legal permanent status (Resident Alien) in U.S. only

Green card/Visa type: _____ Expiration date: _____ (mm/dd/yyyy)

c) Residents residing in the U.S. temporarily (Non-Resident Alien) with valid visa only

Visa #: _____ Visa type: _____ Expiration date: _____ (mm/dd/yyyy)

Form I-94 expiration date: _____ (mm/dd/yyyy) Passport #: _____

Q36–40: If additional space is required for Trust, use Remarks Section.

Trust

34. Situs of Trust: The Trust is subject to the laws of the state of ____________ **35.** Date of Trust: ____________ (mm/dd/yyyy)

36. Name(s) of Grantor(s): ____________

37. Name(s) and title(s) of current Trustee(s): ____________

37a. How long has the Trustee known the Proposed Insured? ____________

37b. What is the nature of the relationship between the Proposed Insured and the Trustee? ____________

37c. Is the Trust ☐ Revocable? ☐ Irrevocable? (Check appropriate box.)

37d. Can interests in the Trust be sold without changing the terms of the Trust? ☐ Yes ☐ No

38. Did the Proposed Insured and/or the Owner retain an attorney to prepare the Trust documents? ☐ Yes ☐ No
If yes, provide name and address of attorney. If no, provide the name and address of the person or entity that did prepare the Trust. Please provide the relationship of the preparer of the Trust to the Proposed Insured.

Name: ____________ Relationship to the Proposed Insured: ____________

Address: ____________

39. Name(s) of current Beneficiary(ies) of the Trust: ____________

39a. What is nature of relationship between Grantor(s) and Beneficiary(ies)? ____________

Q40: A Trust Protector is a third party appointed by the Grantor to provide direction and guidance to the Trustee.

40. Is there a Trust Protector? ☐ Yes ☐ No (If Yes, answer **40a** and **40b**.)

40a. How long has the Trustee known the Trust Protector? ____________

40b. What is the nature of the relationship between the Proposed Insured and the Trust Protector? ____________

BENEFICIARY INFORMATION

Q41: Total percentage must equal 100% for each category of Beneficiary. If percentage shares are left blank, the shares will be deemed equal.

If Beneficiary is a Trust other than Owner, include full name and date of Trust.

41. Beneficiary Information. If no contingent beneficiary is selected, the contingent beneficiary will be: (1) the Proposed Insured's surviving children, if any, in equal shares; or (2) if the Proposed Insured has no surviving children, the contingent beneficiary will be the Proposed Insured's estate.

Full Name	Relationship to Insured	P–Primary C–Contingent	% (Percentage)
		☐ P ☐ C	%
		☐ P ☐ C	%
		☐ P ☐ C	%
		☐ P ☐ C	%

PROPOSED INSURED'S OTHER INSURANCE

Q42: Include any policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity.

42. Do you have any other life insurance/annuity(ies), including ultimate death benefit amounts of any policy/rider in effect with AXA Equitable, its affiliated companies or any other life insurance company? ☐ Yes ☐ No

43. Will the coverage applied for replace, change, or affect any existing policy or contract? ☐ Yes ☐ No
(If the answer to Question 42 or 43 is "Yes," complete the chart below.)

Proposed Insured	Name of Company	Face Amount Plus Riders	Year Issued	Policy/ Contract #	P–Personal G–Group B–Business A–Annuity	To Be Replaced Changed or Affected?	1035 Exchange?
☐ 1 ☐ 2		$			☐ P ☐ B ☐ G ☐ A	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1 ☐ 2		$			☐ P ☐ B ☐ G ☐ A	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1 ☐ 2		$			☐ P ☐ B ☐ G ☐ A	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1 ☐ 2		$			☐ P ☐ B ☐ G ☐ A	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1 ☐ 2		$			☐ P ☐ B ☐ G ☐ A	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1 ☐ 2		$			☐ P ☐ B ☐ G ☐ A	☐ Yes ☐ No	☐ Yes ☐ No

44. Do you have any formal applications pending with AXA Equitable, its affiliated companies or any other life insurance companies? ☐ Yes ☐ No (*If "Yes," complete the chart below. Include ultimate death benefit amounts of any policy/rider.)*

Proposed Insured	Name of Company	Amount Applied For	Competitive or Additional?
☐ 1 ☐ 2		$	☐ Competitive ☐ Additional
☐ 1 ☐ 2		$	☐ Competitive ☐ Additional
☐ 1 ☐ 2		$	☐ Competitive ☐ Additional
☐ 1 ☐ 2		$	☐ Competitive ☐ Additional

45. Including this application, any other applications pending with AXA Equitable, its affiliated companies and other companies, what is the total amount of life insurance that will be placed or put in effect? (Include ultimate death benefit amounts of any policy/rider.)

Proposed Insured 1: $ _____ Proposed Insured 2: $ _____

PROPOSED INSURED'S PERSONAL HISTORY

When providing details in the Remarks Section of the application, include each Proposed Insured's name next to the statement(s) applicable to that Proposed Insured if any question is answered "Yes" for either Proposed Insured.

List details of answers noted "Yes" for questions 46–50 in section after question 50.

	Proposed Insured 1	Proposed Insured 2
46. Have you ever had a driver's license suspended, revoked or restricted?	☐ Yes ☐ No	☐ Yes ☐ No
47. Have you, in the last 5 years, been convicted of, or pled guilty or no contest to, reckless or negligent driving, two or more moving violations or driving under the influence of alcohol or drugs?	☐ Yes ☐ No	☐ Yes ☐ No
48. Have you, in the last 2 years, been disabled for 2 or more weeks?	☐ Yes ☐ No	☐ Yes ☐ No
49. Have you ever had an application for life or health insurance declined, postponed, required an extra premium or other modification or had a life or health policy or contract that was cancelled, recalled or denied renewal?	☐ Yes ☐ No	☐ Yes ☐ No
50. Have you, in the last 10 years, been convicted of, or pled guilty or no contest to, a felony, or are current felony charges pending?	☐ Yes ☐ No	☐ Yes ☐ No

Q49: If "Yes," please state companies and provide full details.

Q50: If "Yes," state offense and penalty, date of probation, duration of probation and end date.

Proposed Insured	Question Number	Date (mm/dd/yyyy)	Description of Event
☐ 1 ☐ 2			
☐ 1 ☐ 2			
☐ 1 ☐ 2			

	Proposed Insured 1	Proposed Insured 2
51. Do you have any plans to travel or reside outside the United States or Canada in the next year (other than a two-week or less vacation to Western Europe or the Caribbean)?	☐ Yes ☐ No	☐ Yes ☐ No
52. Have you, in the last year, flown other than as a passenger or do you plan to do so?	☐ Yes ☐ No	☐ Yes ☐ No
53. Have you, in the last year, engaged or do you plan to engage in motor racing on land or water, underwater diving, skydiving, ballooning, hang gliding, parachuting or flying ultra-light aircraft or other hazardous sports or hobbies?	☐ Yes ☐ No	☐ Yes ☐ No
54. Are you or is the Owner(s) an Active Duty* Member of the Armed Forces?	☐ Yes ☐ No	☐ Yes ☐ No

Q51: If "Yes," complete Foreign Residence and Travel Supplement.

Q52: If "Yes," complete Aviation Supplement.

Q53: If "Yes," complete Avocation Supplement.

Q54: If "Yes," you must also submit a completed and signed Life Insurance/Annuity Disclosure to Active Duty Members of the Armed Forces.

** "Active Duty" means full-time duty in the active military service of the United States and includes members of the reserve component (National Guard and Reserve) while serving under published orders for active duty or full-time training. The term does not include members of the reserve component who are performing active duty or active duty for training under military calls or orders specifying periods of less than 31 calendar days.*

ALCOHOL/DRUG/TOBACCO USE

Q55: If "Yes," complete Substance Usage Supplement.

Q56: Quantity: Specify number of cigarettes or other tobacco products per day.

	Proposed Insured 1	Proposed Insured 2
55. Have you ever received medical treatment or counseling for, or been advised by a physician to reduce or discontinue the use of alcohol or prescribed or non-prescribed drugs?	☐ Yes ☐ No	☐ Yes ☐ No
Do not complete if Proposed Insured is age 0–17.		
56. Have you ever used tobacco or nicotine products in any form (including but not limited to: cigarettes, cigars, cigarillos, pipe, chewing tobacco, nicotine patches or gum)? *(If "Yes," provide details in chart below.)*	☐ Yes ☐ No	☐ Yes ☐ No

Proposed Insured 1

Product	Quantity	Current	Past	# Yrs	Date Stopped (mm/dd/yyyy)
Cigarettes	___ /day	☐	☐		
Cigars	___ /day	☐	☐		
Chewing Tobacco	___ /day	☐	☐		
Other	___/day	☐	☐		

Proposed Insured 2

Product	Quantity	Current	Past	# Yrs	Date Stopped (mm/dd/yyyy)
Cigarettes	___ /day	☐	☐		
Cigars	___ /day	☐	☐		
Chewing Tobacco	___ /day	☐	☐		
Other	___ /day	☐	☐		

MEDICAL CERTIFICATION IF ANOTHER INSURANCE COMPANY'S EXAM IS TO BE USED

Section to be completed only when submitting medical examinations of another insurance company.

57. Proposed Insured	**Name of Insurance Company**	**Date of Exam** (mm/dd/yyyy)
1		
2		

Q60: For Proposed Insured(s) issue age(s) 0-15: the Medical Information Supplement MUST be completed. For Proposed Insured(s) issue age(s) 16 and over: If a full Paramedical or Medical Exam is NOT required, complete the Medical Information Supplement. If a full Paramedical or Medical Exam is required, the Medical Information Supplement is optional. Best practice is to complete the Medical Information Supplement to enable the underwriter to promptly begin the underwriting process.

	Proposed Insured 1	Proposed Insured 2
58. To the best of your knowledge and belief, do the statements in the Exam remain true and complete today? *(If "No," complete the Medical Information Supplement.)*	☐ Yes ☐ No	☐ Yes ☐ No
59. Have you consulted a medical doctor or other practitioner since the Exam indicated in question 57 above? *(If "Yes," complete the Medical Information Supplement.)*	☐ Yes ☐ No	☐ Yes ☐ No

MEDICAL INFORMATION

	Proposed Insured 1	Proposed Insured 2
60. Is a completed Medical Information Supplement attached?	☐ Yes ☐ No	☐ Yes ☐ No

PROPOSED INSURED'S FINANCIAL DETAILS

61a. Income *(Complete chart below.)*

Proposed Insured 1 (If minor, complete for parents)		**Proposed Insured 2**	
Gross Earned Annual Income: (Salary, commissions, bonuses) $	Gross Annual Household Income: $	Gross Earned Annual Income: (Salary, commissions, bonuses) $	Gross Annual Household Income: $
Gross Unearned Annual Income: (Dividends, pension, interest, real estate income, etc.) $	Total Net Worth: $ Liquid Net Worth: (Excluding residence) $	Gross Unearned Annual Income: (Dividends, pension, interest, real estate income, etc.) $	Total Net Worth: $ Liquid Net Worth: (Excluding residence) $

Q61b: Please put additional information or details in the Remarks Section.

	Proposed Insured 1	Proposed Insured 2
61b. In the last 5 years, has either Proposed Insured filed for bankruptcy?	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes," Proposed Insured 1 Chapter: _____ Date opened: _____ (mm/dd/yyyy) Date closed: _____ (mm/dd/yyyy)

Proposed Insured 2 Chapter: _____ Date opened: _____ (mm/dd/yyyy) Date closed: _____ (mm/dd/yyyy)

PURPOSE OF INSURANCE — Complete either a or b

62. a. Personal: ☐ Family protection/Income replacement ☐ Mortgage/Debt repayment ☐ Estate Planning
☐ Charitable/Gifting ☐ Other: _____

b. Business: ☐ Key Person ☐ Buy-Sell ☐ Deferred Comp ☐ Other: _____
☐ Loan indemnification: Amount of loan: $ _____ Duration: _____
Interest charged on loan: _____ Collateral pledged to secure loan: _____

1. Type: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Corp.
2. Proposed Insured's % of ownership in Business/Corporation: Proposed Insured 1: _____
Proposed Insured 2: _____
3. Business/Corporation finances: (Complete chart below for prior fiscal year.)

a. Total assets: $	d. Total liabilities: $	Total net worth (a minus d) $_____
b. Total revenue: (including sales) $	e. Total expenses: $	
c. Net profit: $	f. Fair market value: $	

4. Business insurance on other Owners, Officers, Partners, or Key Persons: (If additional space is required, use Remarks.)

Name and Title	% of Business Owned	Amount In Force or Applied for

5. Has the business filed for bankruptcy and/or reorganization in the past 5 years? ☐ Yes ☐ No
If "Yes," explain: _____

SOURCE OF FUNDS

Q63: If "Yes," submit a copy of the financing or loan agreement.

63. a. Do you intend to finance any of the premium required to pay for this policy through a financing or loan agreement?
☐ Yes ☐ No

b. Indicate the source of funds used to purchase this insurance. *(Check box **and** circle sub-item(s). If more than one box is checked, provide % breakdown.)*

☐ Cash: Death Claim, Gift, Inheritance, Checking, Savings, Money Market, Payroll Deduction: _____%
☐ Borrowing: Mortgage, Personal Loan, Credit: _____%
☐ Policy-Related: Surrender/Exchange, Policy Loan, Dividend, Withdrawal: _____%
☐ Sale of 401k Mutual Fund Shares: _____%
☐ Sale of Other Qualified or Non-Qualified Mutual Fund Shares: _____%
☐ Sale of Existing Pension Plan Assets, Stocks, Bonds, CDs: _____%
☐ Other: Sale of (i) Car, (ii) Home, (iii) Business, or (iv) Other Asset (specify: _____),
(v) Legal Settlement, (vi) Lottery/Gaming Proceeds, (vii) Other: _____ : _____%

64. a. TO THE OWNER: Do you intend to use or transfer the policy for any type of pre-death financial settlement, such as viatical settlement, senior settlement, life settlement, or for any other settlement in the secondary market? ☐ Yes ☐ No

b. TO THE PROPOSED INSURED(S): Do you intend to cause the Owner to use or transfer the policy for any type of pre-death financial settlement, such as viatical settlement, senior settlement, life settlement, or for any other settlement in the secondary market?

Proposed Insured 1	Proposed Insured 2
☐ Yes ☐ No	☐ Yes ☐ No

SOURCE OF FUNDS CONT'D

Questions 65–67 are not required if completing Financial Supplement II.

When providing details in the Remarks Section of the application, include each Proposed Insured's name next to the statement(s) applicable to that Proposed Insured if any question is answered "Yes" for either Proposed Insured.

	Proposed Insured 1	Proposed Insured 2
65. Has either Proposed Insured(s), Owner, or Beneficiary, or any Trust or other entity in which they have an interest, sold or transferred any life insurance policy or an interest therein, within the last 5 years? If "Yes," please state the details of the transaction including name of each company and the number of years the policy was in effect. (Details to be provided in Remarks Section.)	☐ Yes ☐ No	☐ Yes ☐ No
66. Has any compensation or other inducement (including cash, offers or discussions of free insurance, any forgiveness or potential forgiveness of any debt, or other benefits) been offered directly or indirectly to any of the following in connection with applying for and or purchasing of this policy: the Proposed Insured, the Owner or Beneficiary, the Beneficiary of any Trust owning the policy and/or the Owner of any legal entity owning the policy, or is there any expectation of receiving any such compensation or inducement? If "Yes," please state the compensation or inducement that will be received or could be received and by whom. (Details to be provided in Remarks Section.)	☐ Yes ☐ No	☐ Yes ☐ No
67. Will any other person or entity (i.e., a person or entity different than the owner or beneficiary initially named in the policy) provide any funding, financing, or guarantees for any premium payment on the policy, or are any potential or alternate sources of funding, financing or guarantees under consideration?	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes," please submit a copy of all actual or potential funding, financing, or guarantee documents, and a detailed, third-party prepared Personal Financial Statement signed by the preparer. The above documents are not required if funding is part of a split-dollar arrangement (1) between the employer and the employee or a corporation and its shareholders, provided that the employment and/or shareholder relationship was not entered into to establish a premium funding arrangement, or (2) between the insured and another family member (i.e., in either case, there is no third-party unaffiliated entity or non-related individual involved). Please also answer the following questions:

a. State why the premiums will or may be funded or financed, or why other guarantees will or may be provided.

_____

_____

_____

b. State the name of the other person or entity providing the actual or potential funding, financing, or guarantees and role (e.g., lender, guarantor, etc.).

_____

_____

_____

_____

c. State how the actual or potential funding, financing or guarantees will be repaid, what collateral will be used, and whether the lender's or guarantor's ability to recover is limited to the value of the policy.

_____

_____

_____

_____

d. Will a letter of credit or personal guarantee be posted?
(If "Yes," state the details, including details relating to the assets backing the letter of credit.)

_____

_____

_____

_____

e. If an employer-sponsored split-dollar arrangement, please indicate the amount of time the employee or shareholder has been affiliated with the entity(ies): _____ years.

COMPLETE IF MONEY IS PAID WITH APPLICATION

Q68: All premium checks must be payable to company selected on page 1 of application. Do not make checks payable to financial professional or leave the payee blank.

68. Amount paid with this Application: $_____

a. Has the Owner(s) read, signed and received the Temporary Insurance Agreement/Receipt? ☐ Yes ☐ No

b. Does the Owner(s) understand and agree to all of the conditions of the Temporary Insurance Agreement/Receipt? ☐ Yes ☐ No

c. Has the Proposed Insured(s) read and signed the the Temporary Insurance Agreement/Receipt? ☐ Yes ☐ No

d. Does the Proposed Insured(s) understand and agree to all of the conditions of the Temporary Insurance Agreement/Receipt? ☐ Yes ☐ No

If any of the above questions are answered "No," or any Insurability Question on the Temporary Insurance Agreement/Receipt is answered "Yes," a premium may not be paid before the policy is delivered and **no temporary insurance will be in effect**.

REMARKS

Please provide details for any questions. Reference question number with remarks.

AUTHORIZATIONS

ACKNOWLEDGMENT OF OUR UNDERWRITING PROCESS

I (we) acknowledge that I (we) have reviewed the statement of the Underwriting Process of the Company(ies) (the "Statement") which describes from whom and why the Company(ies) obtain information on my (our) insurability, to whom such information may be reported and how I (we) may obtain it. The Statement contains the notice required by the Fair Credit Reporting Act.

I (we) acknowledge that in the event the Company(ies) use lab results from another insurance company authorized by me (us), it does so with the belief that I (we) have satisfied all consent and disclosure procedures for the other insurance company.

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

I (we) authorize any physician, hospital, clinic, medical practitioner, medical testing laboratory, pharmacy, prescription drug or pharmacy benefit manager or administrator or viatical company, life settlement company, viatical or life settlement broker/provider, other health care provider, health plan or insurance company (including our Company(ies) with respect to other coverages) and the Medical Information Bureau to disclose to the Company(ies) and its authorized representatives any and all information, whether fact or opinion, they may have about any diagnosis, treatment, prognosis, genetic records, findings and/or results regarding my (our) past, present or future physical or mental condition.

AUTHORIZATION TO OBTAIN NON-HEALTH INFORMATION

I (we) authorize any employer, business associate, government unit, financial institution, consumer reporting agency, the Medical Information Bureau, my (our) insurance agency and my (our) financial professional to disclose to the Company(ies) and its authorized representatives any information they may have about my (our) occupation, avocations, insurance activities, finances, driving record, character and general reputation. I (we) authorize the Company(ies) to obtain investigative consumer reports, as appropriate.

PURPOSE OF AUTHORIZATIONS

I (we) understand that the information obtained will be used by the Company(ies) to determine my (our) eligibility for life insurance coverage and such other uses specified in accordance with the Statement attached to this application. In addition, information may be disclosed to the Medical Information Bureau (MIB).

COVERAGE CONDITIONS

I (we) understand that the Company(ies) is conditioning the issuance of coverage on the provision of this authorization, and that, while I (we) may refuse to sign this authorization, my (our) refusal to do so could result in coverage not being issued.

ADDITIONAL AUTHORIZATIONS

You have advised me (us) that the Company(ies) may request additional authorizations in order to obtain the information the Company(ies) needs to complete its review of my (our) application and, if the policy is issued, in connection with any claim asserted under the policy, I (we) understand that I (we) am (are) not obligated to provide these additional authorizations but that, if I (we) choose not to provide them, this application and any claim made under the policy, if issued, may be rejected.

DURATION

Unless otherwise revoked, I (we) agree that this authorization will expire on the earlier of the date that the Company(ies) declines my application for coverage or, if a policy is issued, 24 months from the date of my (our) application. I (we) understand that I (we) may revoke my (our) authorizations at any time, except to the extent that the Company(ies) has taken action in reliance on this authorization, and that this application and any claim made under the policy, if issued, may be rejected. My (our) revocation must be submitted in writing to: Corporate Chief Underwriter, 1290 Avenue of the Americas, New York, New York 10104.

AUTHORIZATION IF BANK DRAFT IS ELECTED

I (we) request and authorize you to charge monthly or quarterly my (our) checking account to pay premiums due under the policy(ies). It is understood that debits will be made automatically after the effective date determined by the Company checked above, and if charges are overlooked or inadvertently not made, the Company checked above may charge my (our) account at a later date provided the policy(ies) is (are) active.

I (we) understand that the use of the Bank Draft Payment Plan does not change any policy provision.

I (we) understand this authorization is to remain in full force and in effect, unless terminated. I (we) understand this Plan may be terminated by the depositor, the Policy Owner or the Company checked above upon 30 days written notice to the other parties or if any charge due is not paid or is reversed by the Bank. I (we) understand this Plan may be terminated upon closing of my account with you or upon receipt of my bankruptcy.

I (we) understand if this Plan is terminated, premiums for regular or scheduled premium policies will be payable directly to the Company checked on the page one of this application.

I (we) agree that this Plan may be terminated if any debit is not honored by the Bank or Depository named for any reason. I (we) further agree that if any such charge is dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance.

COPY OF AUTHORIZATIONS

I (we) have a right to ask for and receive true copies of this Acknowledgment and Authorization Form and all other authorizations signed by me (us). I (we) agree that reproduced copies will be as valid as the original.

AGREEMENT. Each signer of this Application agrees that:

1) The statements and answers in all parts of this Application and any application supplements are true and complete to the best of my (our) knowledge and belief. We (the Company checked on page one of this application) will rely on them in acting on this Application.
2) Except when the required money is paid with this Application and as stated in the Temporary Insurance Agreement/Receipt, no insurance shall take effect on this Application: (a) until the date the policy and all amendments are delivered to the Owner(s) and all delivery requirements have been completed; (b) before any Register Date of the policy; and (c) unless the statements and answers in all parts of this Application and any applicable supplements continue to be true and complete to the best of my (our) knowledge and belief, without material change, as of the latest of the date: (i) the policy and all amendments are delivered to the Owner(s); (ii) all delivery requirements have been completed; and (iii) the full initial premium is paid.
3) If temporary insurance is required, the full initial premium must accompany this Application; the Proposed Insured(s) and Owner(s) understand and agree to the terms of the Temporary Insurance Agreement/Receipt and have executed and the Owner(s) has received a copy of the Temporary Insurance Agreement/Receipt.
4) The Temporary Insurance Agreement/Receipt states the conditions that must be met before any insurance takes effect if the full initial premium is paid with this Application. Temporary insurance is not provided for a policy or benefit applied for under the terms of a guaranteed insurability option or a conversion privilege.
5) No financial professional or medical examiner has authority to modify this Application or its supplements, the Temporary Insurance Agreement/Receipt (if applicable), or to waive any of our rights or requirements. We shall not be bound by any information unless it is stated in Application Part 1, the Medical Information Supplement, or Application Part 2 (Paramedical or Medical exam).
6) I (We) acknowledge receipt of the Living Benefits Brochure (Accelerated Death Benefit Rider Brochure), where applicable.
7) I (We) acknowledge that no representation is made that a particular rate or risk classification is being offered based on the information provided in response to the policy Application questions.
8) If applicable, the trustee(s) represent(s) that the Trust named as Owner is allowed to purchase life insurance and securities under the trust document. I (We) further represent that beneficial interests in the Trust are only for parties related by blood or law, those who have a substantial interest in the Proposed Insured(s) engendered by love and affection, or those who have a lawful and substantial economic interest in the continued life of the Proposed Insured(s).

Taxpayer Identification Number Certification…Under the penalties of perjury, I (we) certify that (i) the number showing on this form is my (our) correct Taxpayer Identification Number (Social Security Number, Employer Identification Number or other Taxpayer Identification Number), and (ii) I (we) am (are) not subject to backup withholding because (A) I (we) am (are) exempt from backup withholding or (B) I (we) have not been notified by the Internal Revenue Service (IRS) that I (we) am (are) subject to backup withholding as a result of a failure to report all interest or dividends or (C) the IRS has notified me (us) that I (we) am (are) no longer subject to backup withholding and (iii) I (we) am (are) a U.S. person (including a U.S. resident alien).

Certification Instructions: You must cross out item (ii) above if you have been notified by the Internal Revenue Service that you are currently subject to backup withholding because you have failed to report all interest or dividends on your tax return.

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

FOR THE APPLICANT'S PROTECTION, THE LAWS OF CERTAIN STATES REQUIRE THIS NOTICE: ANY PERSON WHO WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, FILES ANY APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT AS TO ANY MATERIAL FACT MAY BE GUILTY OF INSURANCE FRAUD, WHICH MAY RESULT IN LOSS OF COVERAGE UNDER THIS POLICY AND MAY SUBJECT THE APPLICANT/CLAIMANT TO CRIMINAL PROSECUTION.

D.C.: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN addition, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

WASHINGTON: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

I (We), the undersigned, by my (our) signature(s) below understand that I (we) am (are) agreeing to all the terms and conditions of this application, including, but not limited to, the Acknowledgment and Authorization.

X _____ **X** _____

Signature of Proposed Insured 1 (Parent, Guardian, or Applicant if Proposed Insured Is a Child, Issue Ages 0–14)

Signature of Proposed Insured 2

X _____ _____ _____

Signature of Owner or Applicant If Not Proposed Insured(s)
(If corporation, print firm's name, signature and title of authorized officer.)
(If Trust, signature of trustee.)

Signed by Owner at City, State

Dated on (mm/dd/yyyy)

FINANCIAL PROFESSIONAL TO COMPLETE THIS SECTION

Will any existing insurance be replaced, changed or affected (or has it been) assuming the insurance applied for will be issued? ☐ Yes ☐ No

If "Yes," is the information provided in question 43 complete and accurate? ☐ Yes ☐ No

If "No," provide details: _____

I certify that I have asked and recorded completely and accurately the answers to all questions on the fully completed application Part 1, and know of nothing affecting the risk that has not been recorded herein.

☐ **I have** witnessed the signature required on the fully completed Part 1.

☐ **I have not** witnessed the signature required on the fully completed Part 1. (Explain below.)

_____

_____

X _____

Signature of Licensed Financial Professional/Insurance Broker

Dated on (mm/dd/yyyy)

X _____

Print Licensed Financial Professional's Name

AXA EQUITABLE

1290 Avenue of the Americas, New York, NY 10104

(Select One)

- ☐ AXA Equitable Life Insurance Company
- ☐ AXA Equitable Life and Annuity Company
- ☐ MONY Life Insurance Company of America

Optional Benefits Supplement

OPTIONAL BENEFITS SUPPLEMENT FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

Name of Proposed Insured _____ Policy No. (If known) _____ Date of Birth _____ (mm/dd/yyyy)

Name of Additional/Joint Proposed Insured _____ Date of Birth _____ (mm/dd/yyyy)

TERM LIFE

- ☐ Disability Premium Waiver Rider
- ☐ Children's Term Insurance Rider *(complete Children's Term Insurance Rider Supplement)*
  Amount $_____
- ☐ Other _____

ATHENA UL-LPR (DB OPTION A ONLY)

- ☐ Disability Waiver of Monthly Deductions Rider
- ☐ Children's Term Insurance Rider *(complete Children's Term Insurance Rider Supplement)*
  Amount $_____
- ☐ Option to Purchase Additional Insurance Rider
  Amount $_____
- ☐ Cash Value Enhancement Rider
- ☐ Return of Premium Death Benefit Rider
  Premium Percentage _____%* (specify percentage from 15% minimum to 100% maximum)
  Accumulation Rate _____%* (specify percentage from 0% minimum to 6% maximum)
- ☐ Long-Term Care Services Rider *(complete Long-Term Care Services Rider Supplement)*†
- ☐ Other _____

ATHENA UL-DB

- ☐ Disability Waiver of Monthly Deductions Rider
- ☐ Children's Term Insurance Rider *(complete Children's Term Insurance Rider Supplement)*
  Amount $_____
- ☐ Option to Purchase Additional Insurance Rider
  Amount $_____
- ☐ Cash Value Plus Rider
- ☐ Return of Premium Death Benefit Rider
  Premium Percentage _____%* (specify percentage from 15% minimum to 100% maximum)
  Accumulation Rate _____%* (specify percentage from 0% minimum to 6% maximum)
- ☐ Long-Term Care Services Rider *(complete Long-Term Care Services Rider Supplement)*†
- ☐ Other _____

ATHENA SUL III

- ☐ Estate Protector Rider (EPR benefit is a maximum of 122% of the base policy face amount)
- ☐ Lapse Protection Rider (DB Option A only)
- ☐ Cash Value Enhancement Rider
- ☐ Return of Premium Death Benefit Rider
  Premium Percentage to be Returned _____%* (specify percentage from 15% minimum to 100% maximum)
  Accumulation Rate _____%* (specify percentage from 0% minimum to 6% maximum)
- ☐ Other _____

ATHENA UL-ESLI

- ☐ Disability Waiver of Monthly Deductions Rider
- ☐ Return of Premium Death Benefit Rider
  - Premium Percentage _____%* (specify percentage from 15% minimum to 100% maximum)
  - Accumulation Rate _____%* (specify percentage from 0% minimum to 6% maximum)
- ☐ Other _____

INTEREST SENSITIVE WHOLE LIFE (ISWL)

- ☐ Disability Premium Waiver Rider
- ☐ Children's Term Insurance Rider *(complete Children's Term Insurance Rider Supplement)*
  - Amount $_____
- ☐ Automatic Premium Loan Option
- ☐ Other _____

*** Percentages must be stated in whole numbers (no fractions or decimals).**
† Not available in Florida and North Carolina.

I (we) represent that the options indicated in this Supplement reflect my (our) selections.

X _____ Date (mm/dd/yyyy) _____
Signature of Proposed Insured

X _____ Date (mm/dd/yyyy) _____
Signature of Additional/Joint Proposed Insured

X _____ Date (mm/dd/yyyy) _____
Signature of Owner, if other than the Proposed Insured(s), who agrees to be bound by the representations and agreements in this and any other part of the application.

I certify that I have recorded completely and accurately the options requested by the Proposed Insured(s) and Owner, if other than the Proposed Insured(s).

X _____ Date (mm/dd/yyyy) _____
Signature of Licensed Financial Professional/Insurance Broker

SERFF Tracking Number:	*ELAS-125895993*	*State:*	*Arkansas*
Filing Company:	*AXA Equitable Life and Annuity Company*	*State Tracking Number:*	*40849*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Informational AMIGV-2009 et al (AXAEQLA)*		
Project Name/Number:	*Individual Life/AMIGV-2009*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ELAS-125895993*	*State:*	*Arkansas*
Filing Company:	*AXA Equitable Life and Annuity Company*	*State Tracking Number:*	*40849*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Informational AMIGV-2009 et al (AXAEQLA)*		
Project Name/Number:	*Individual Life/AMIGV-2009*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 11/11/2008

Comments:

Please see Filing Description.